		AND HUMAN SERVICES  & MEDICAID SERVICES	Rece	PRINTED: 12/19/200 FORM APPROVED OMB NO. 0938-039
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		095015	B. WING_	12/06/2007
	OVIDER OR SUPPLIER	LTH CARE CENTER		TREET ADDRESS, CITY, STATE, ZIP CODE  1380 SOUTHERN AVE SE  WASHINGTON, DC 20032
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE
F 000	December 3 through	ation survey was conducted h 6, 2007. The following ased on record review,	F 00	0
F 224	observations, and in The sample include census of 177 resid and five (5) supplen	nterviews with the facility staff. d 27 residents based on a ents on the first day of survey mental residents.	F 22	Disclaimer Preparation or execution of this Plan of Correction ("POC")
F 221 SS=D	physical restraints in	e right to be free from any mposed for purposes of lience, and not required to treat	F 22	does not constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the Statement of Deficiencies ("SOD"). The POC is prepared and executed solely because it is required under the law.
	Based on observation interviews for a same four (4) residents id determined that the	ons, record review and staff aple of 27 residents, one (1) of entified with restraints, it was clinical record lacked evidence was the least restrictive device		By this response, Carolyn Boone Lewis Health Care Center acknowledges receipt of the SOD and alleges that it is in compliance. Accordingly, this POC is submitted as written allegation of compliance effective December 28, 2007.
	During the review of orders signed and of an original order da "Vest Posey jacket" every two (2) hours	f the clinical record, physician's lated November 16, 2007 with te of May 15, 2007, indicated to protect pt. (patient) release for mobility and circulation in esident #2 has a history of falls.	~	
	Resident #2 was ob a wheelchair in a Ve	07 at approximately 9:30 AM, served sitting in the day room in est Posey jacket with the Velcrok, the straps attached		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Udministrator

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these locuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 12/19/2007 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		12/06/2007	
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	LTH CARE CENTER	13	ET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS- COMPLE	
F 000	December 3 throug deficiencies were be observations, and in The sample include	ation survey was conducted h 6, 2007. The following ased on record review, nterviews with the facility staff. d 27 residents based on a ents on the first day of survey	F 000			
F 221 SS=D	The resident has the physical restraints is discipline or converthe resident's medical This REQUIREMENT Based on observation interviews for a san four (4) residents id determined that the that a vest restraint for Resident #2.  The findings include During the review of orders signed and original order day "Vest Posey jacket every two (2) hours bed/wheelchair." For December 3, 20 Resident #2 was of a wheelchair in a Vest Posey in a vest Posey in the review of t	e right to be free from any mposed for purposes of hience, and not required to treat cal symptoms.  AT is not met as evidenced by: ons, record review and staffingle of 27 residents, one (1) of entified with restraints, it was clinical record lacked evidence was the least restrictive device	F 221	<ol> <li>F 221 483.13(a) PHYSICAL RESTRAINTS</li> <li>Unit Manager referred residents screen on 12-07-07. recommended a self release which is the least restrictive was placed on residents' what 12-14-07.</li> <li>All other residents identified restraints has been assessed least restrictive device and to rehab for screens as needs.</li> <li>Licensed staff were in-served 12-07-07 on the use of restrictive by Unit Manager and the referral process for rehast screens.</li> <li>Random audits will be concensure the process is being and monitored in quarterly</li> </ol>	Rehab e seat belt . Seat belt heelchair on  d with I for the referred led. iced on braints  db  ducted to followed	07
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITLE	(X6) DATE	

Calanthia Green

administration

12-28-07

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	• •	095015	B. WING	• • • • • • • • • • • • • • • • • • • •	12/0	06/2007
	N BOONE LEWIS H	EALTH CARE CENTER	136	ET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	( STATEMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 221	to the jacket were	page 1 e wrapped around the lower rims of The resident was pulling on the It to remove it saying that he/she	F 221			
	the resident was the hallway acros station. He/she w to remove it; the	2007 at approximately 5:15 PM, observed in his/her wheelchair in as from the first floor nurse's vas pulling the vest up in an attempt vest was observed anchored at the eneath his/her chin.				
	form for vest rest	nical record revealed a consent raint use signed and dated by the sible party on May 15, 2007.				
		re plan for restraint use for safety October 24, 2007.			•	
	signed and dated therapist indicate [he/she] is able to	Screening" form in the record I October 29, 2007 by the physical d, "Pt. using Posey Vest which o remove on occasion allowing at a fall[She/he] is on the least at this time."			•	
		d evidence that other devices ons had been tried.				
	face-to-face inter Employee #12. The vest is the most requently used observation, the	2007 at approximately 12:30 PM, a view was conducted with The employee stated, "This type of estrictive; that type of restraint is ed at the present time." During resident was unable to remove the attempts. The record was reviewed 2007.				
F 246	483.15(e)(1) ACC	COMMODATION OF NEEDS	F 246			

1 equel 1/4/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015		6		42/0	C/0007
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		880 SOUTHERN AVE SE	12/06/2007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 246 SS=D	services in the facili accommodations of preferences, except	ight to reside and receive	F	246	F 246 483.15(e) (1) ACCOMMODATION OF NEE  1. Residents' #122, 126, 135, 23 and 334 clocks that failed to k correct time during survey per were removed immediately.	4, 243 eep	
	Based on observation determined that cloowere not functional.	ons during the initial tour, it was cks located in residents' rooms. These observations were ce of Employees #1, 2, 3 and			<ol> <li>All other residents' rooms and areas in the facility were clocks are located were checked for proper functioning and were moved and replaced as needed</li> <li>Purchasing Director was in-semonitoring of clocks in resider and other areas where clocks a in the facility by the Educator 12-26-07.</li> </ol>	re re- l. rviced on nts' rooms are located on	
F 253 SS=E	2007 between 8:30 observed that clock following rooms: 12: (6) of 36 resident ro Employees #1, 2, 3 findings at the time 483.15(h)(2) HOUS The facility must promaintenance service	and 11 acknowledged the	F	253	<ol> <li>Purchasing Director will condi- rounds to ensure clocks are fur properly. Findings will be rep quarterly CQI.</li> </ol>	nctioning	12-28-07
		IT is not met as evidenced by: ons during the survey period, it t housekeeping and					

PRINTED: 12/19/2007

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 095015 12/06/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE CAROLYN BOONE LEWIS HEALTH CARE CENTER WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG TAG F 246 Continued From page 2 F 248 F 246 483.15(e) (1) SS=D **ACCOMMODATION OF NEEDS** A resident has the right to reside and receive 1. Residents' #122, 126, 135, 234, 243 services in the facility with reasonable and 334 clocks that failed to keep accommodations of individual needs and preferences, except when the health or safety of the correct time during survey period individual or other residents would be endangered. were removed immediately and replaced on 12-10-07. 2. All other residents' rooms and areas in the facility were This REQUIREMENT is not met as evidenced by: clocks are located were checked for proper functioning and were re-Based on observations during the initial tour, it was moved and replaced as needed. determined that clocks located in residents' rooms were not functional. These observations were 3. Purchasing Director was in-serviced on made in the presence of Employees #1, 2, 3 and monitoring of clocks in residents' rooms 11. and other areas where clocks are located in the facility by the Educator on The findings include: 12-26-07. During the initial tour of the facility on December 3, 4. Purchasing Director will conduct monthly 2007 between 8:30 AM and 10:00 AM, it was rounds to ensure clocks are functioning observed that clocks failed to keep time in the properly. Findings will be reported in 12-28-07 following rooms: 122, 128, 135, 234, 243, 334 in six quarterly CQI. (6) of 36 resident rooms observed. Employees #1, 2, 3 and 11 acknowledged the findings at the time of the observations. F 253 483.15(h)(2) HOUSEKEEPING/MAINTENANCE F 253 SS=E The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it

was determined that housekeeping and

19108

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095015		····B. WIN	B. WING		12/06/2007	
CAROLY		EALTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	D BE CROSS-	(X5) COMPLETION DATE
F 253	that the facility was anitary manner a baseboards, ceilin machine, window washing machines furniture, doors, difloor shower room overbed lights and rooms. The environ December 3, 2007 in the presence of and 11. A tour of December 3, 2007 Employee #5.  The findings included the findings included the findings included the findings included the findings in the following room the first floor.  3. Wax and dirt but the following room the first floor.  4. Bed frames with observed in the following room the first floor.	ices were not adequate to ensure is maintained in a safe and is evidenced by: soiled gitles, corners, bed frames, ice tracts, front window of facility is, damaged/marred walls, usty overbed lights, missing 2nd tiles, broken front panels on it odors detected in residents bromental tour was conducted on from 8:30 AM through 11:30 AM Employees #1, 2, 3, 4, 5, 6, 7, the laundry was conducted on at 2:15 PM in the presence of it is in 13 of 36 rooms observed.  It is were observed in rooms 130 of 12 rooms observed on the 1st in 13:128, 130, 135, 136, 142, 144, 136 of 12 rooms observed on in accumulated dust were llowing rooms: 246, 237, 318, we (5) of 24 resident rooms	F	253	F 253 483.15(h)(2) HOUSEKEEPING/MAINTI #1, #2, #3, #4, # 5, #6  1. The soiled, marred/dar baseboards in rooms 1 136, 137, 139, 141, 14 2 <sup>nd</sup> and 3rf floor showe were cleaned on 12-26 stained tile in room 130 were removed and replimmediately during sur the wax and dirt build to 128, 130, 135, 136, 142 145 and 147 were cleaned 12-27-07. Bed frames si accumulated dust in room 318, 321 and 337 were dimmediately. The 3 <sup>rd</sup> flomachine dispensing spowith dust and debris was on the day it was sited. window tracks in rooms 130, 136, 137, 142, 144, 147, 207, 230, 246, 308, 346 were cleaned immediated.	naged 30, 5, 147, r rooms 07, the 0 and 137 aced vey period, up in rooms 2, 144, ed on ited with ms 246, 237, cleaned oor panty ice ut soiled is cleaned The soiled 126, 128, 145, 324 and	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/19/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R WING 095015 12/06/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE CAROLYN BOONE LEWIS HEALTH CARE CENTER WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION PREFIX OR LSC IDENTIFYING INFORMATION) TAG TAG F 253 Continued From page 3 F 253 maintenance services were not adequate to ensure that the facility was maintained in a safe and F 253 483.15(h)(2) sanitary manner as evidenced by: soiled HOUSEKEEPING/MAINTENANCE baseboards, ceiling tiles, comers, bed frames, ice machine, window tracts, front window of facility #1, #2, #3, #4, #5, #6 washing machines, damaged/marred walls, furniture, doors, dusty overbed lights, missing 2nd floor shower room tiles, broken front panels on The soiled, marred/damaged overbed lights and odors detected in residents baseboards in rooms 119, rooms. The environmental tour was conducted on 123, 128.130, 136, 137, 139, December 3, 2007 from 8:30 AM through 11:30 AM 141, 144, 145, 147, 2nd and in the presence of Employees #1, 2, 3, 4, 5, 6, 7, 3rd floor shower rooms were and 11. A tour of the laundry was conducted on cleaned on 12-26-07, the December 3, 2007 at 2:15 PM in the presence of stained tile in room 130 and Employee #5. 137 were removed and replaced immediate during survey The findings include: period, the wax and dirt build up in rooms 128, 130, 135, 1. Soiled, marred/damaged baseboards were 136, 142, 144, 145 and 147 observed in the following rooms: 119, 123, 128, were cleaned on 12-27-07. Bed 130, 138, 137, 139, 141, 144, 145, 147, 2nd and 3rd frames sited with accumulated floor shower rooms in 13 of 36 rooms observed. dust in rooms 246, 237, 318, 321 and 337 were cleaned 2. Stained ceiling tiles were observed in rooms 130 immediately. The 3<sup>rd</sup> floor panty ice and 137 in two (2) of 12 rooms observed on the 1st machine dispensing spout soiled floor. with dust and debris was cleaned on the day it was sited. The soiled 3. Wax and dirt build-up in comers was observed in window tracks in rooms 126, 128, the following rooms: 128, 130, 135, 136, 142, 144, 130 136, 137, 142, 144, 145, 147, 145, and 147 in eight (8) of 12 rooms observed on 207, 210, 230, 246, 308, 324 the first floor. 334 and 346 were cleaned immediately. 4. Bed frames with accumulated dust were observed in the following rooms: 246, 237, 318, 321, and 337 in five (5) of 24 resident rooms observed on the 2nd and 3rd floors.

5. The 3rd floor pantry ice machine dispensing

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		A. BUILDING	·		
		095015 B. WING			12/06/2007
•	ROVIDER OR SUPPLIER	LTH CARE CENTER	13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLÉTION
F 253	spout was observed dust and debris in o observed on the 3rd 6. Soiled window trafollowing rooms: 121 145, 147, 207, 210, 346 in 17 of 36 resid 7. One (1) of two (2) with a black substar window.  8. Damaged, marred in the following room 313, 338, 318, 338, rooms, and 3rd floor observed.  9. Broken chairs we areas: 3rd floor smc arm chairs, 3rd floor arm chairs, and 2nd six (6) chairs.  10. Damaged doors areas: 2nd floor smc door, 1st floor day roand 2nd floor day roand 2nd floor day roand 2nd floor day roand 378 in observed.	I soiled with an accumulation of ne (1) of one (1) ice machine	F 253	<ol> <li>All other residents rooms an Areas That could be affected were inspected by Director Environmental Services to that baseboards are clean, tiles are free of stains, there No wax builds up in corner Frames are free from dust a Ice machine on 3<sup>rd</sup> floor is from dust and debris and w tracks in residents rooms and throughout the facility a not soiled.</li> <li>In-services were given on 1 on cleaning of baseboards, soiled ceiling tile to mainter cleaning wax and dirt build cleaning of bed frames, the of the ice machine and the of window tracks by the Di Of Environmental Services</li> <li>Director of Environmental S will make monthly rounds to ensure baseboards are clean tiles are free of stains, there is no wax build up in corners bed frames are free from dust and debris, ice machine on 3<sup>rd</sup> floor is free from dust and debris and window tracks in residents rooms and throughouthe facility are not soiled and refindings in Quarterly CQI.</li> </ol>	of ensure  is s, bed and debris, free indow  are  2-20-07 reporting nance dept. up in corners cleaning cleaning rector ervices

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WIN	3. <u></u>	<u> </u>	12/0	6/2007
	N BOONE LEWIS H	EALTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHERN AVE SE (ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 253	spout was observed ust and debris in observed on the 3 conserved on the 4 conserved on the 5 conserved on th	red soiled with an accumulation of n one (1) of one (1) ice machine	F 2	253	<ol> <li>Cited black substance on inner front window on washer was 12-4-07</li> <li>All other washers were inspect laundry staff and washers were as needed.</li> <li>Staff was in-serviced on 12-2 Director of Environmental Second Cleaning and maintenance of</li> <li>Monitoring will be done by laweekly and finding will be requarterly CQI.</li> <li>The walls cited in rooms 137, 141, 312, 313, 338, 338, and 2<sup>nd</sup> floor shower and 3<sup>rd</sup> floor pantry as may walls during the survey part will be repaired by 12-30.</li> <li>All other residents room inspected for marred/sc by the maintenance staff be repaired as needed.</li> <li>In-service was given by Maintenance to mainten making rounds and repair marred/scarred walls in rooms and other areas of the facility.</li> </ol>	cleaned on  cted by re cleaned  21-07 by rvices on washers.  aundry staff ported in  123, 136, 318 rooms arred/scarred beriod 0-07.  as were arred walls ff and will  Director of lance staff on iring	12-28-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUI	
		095015	B. WING	3		12/0	6/2007
	N BOONE LEWIS HEA	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHERN AVE SE L'ASHINGTON, DC 20032	12/0	<i>51</i> <b>2</b> 007
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 253	dust and debris in o observed on the 3rd 6. Soiled window tra following rooms: 126 145, 147, 207, 210,	soiled with an accumulation of ne (1) of one (1) ice machine	F 2		4. Monthly rounds will be d Maintenance staff to ensu are not marred/scarred an will be reported in Quarte  #9	ure walls  Inding  Court Cour	12-28-07
	7. One (1) of two (2) with a black substar window.  8. Damaged, marred in the following room 313, 338, 318, 338,	working washers was observed ace on the inner part of the front d/scarred walls were observed as: 123, 136, 137, 141, 312, 2nd and 3rd floor shower pantry in 12 of 36 rooms			<ol> <li>The broken chairs sited d survey in the 3<sup>rd</sup> floor sm 3<sup>rd</sup> floor dining room and floor dining room were retimmediately.</li> <li>All other areas that could be Were inspected by Directo Environmental Services at were removed or repaired and survey in the survey of the survey of</li></ol>	oking room I the 2 <sup>nd</sup> moved  be affected r of nd chairs	
	areas: 3rd floor smo arm chairs, 3rd floor arm chairs, and 2nd six (6) chairs.  10. Damaged doors areas: 2nd floor sm door, 1st floor day ro and 2nd floor day ro 11. Overbed lights v accumulation of dus 136, 137, 139, 142, 321, 337, and 378 in observed.	re observed in the following king room one (1) of three (3) dining room one (1) of three (3) floor dining room three (3) of were observed in the following oking room one (1) of one (1) oom one (1) of two (2) doors, from one (1) of one (1) door.  were observed with an at in the following rooms: 130, 144, 145, 147, 237, 246, 312, in 14 of 36 resident rooms  observed missing in the 2nd			<ul> <li>3. Housekeeping staff were in-12-20-07 on inspecting chair. The facility on their assigned to ensure compliance.</li> <li>4. Findings will be reported in CQI.</li> </ul>	rs throughou d units daily	12-28-07
		n one (1) of one (1) shower					

1/4/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SUR COMPLET		
	44		B-WING			
095015		095015	D. W. W		12/0	5/2007
	OVIDER OR SUPPLIER  N BOONE LEWIS HE	ALTH CARE CENTER		REET ADDRESS, CITY, STATE, ZIP COL 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 253	Continued From pa	_	F 253	#10, #12 #13		
	dust and debris in observed on the 3r 6. Soiled window to following rooms: 12 145, 147, 207, 210 346 in 17 of 36 res 7. One (1) of two (2)	d soiled with an accumulation of one (1) of one (1) ice machine of floor.  Tracts were observed in the 26, 128, 130, 136, 137, 142, 144, 1, 230, 246, 308, 324, 334, and ident rooms observed.		<ol> <li>Damaged doors on 2 and 1st floor day roo survey period was reg 12-24-07. The broke 2<sup>nd</sup> floor shower room by 01-10-08. The broke over bed light in a were repaired the san</li> <li>All other doors, show over bed light panels</li> </ol>	om cited during paired on en tile in the m will be repaired oken front panel of rooms 126 and 142 ne day cited.	
	8. Damaged, marroin the following rooms, 313, 338, 318, 338 rooms, and 3rd floor observed.  9. Broken chairs wareas: 3rd floor smarm chairs, 3rd floor smarm chairs, 3rd floor	ed/scarred walls were observed was: 123, 136, 137, 141, 312, 2nd and 3rd floor shower or pantry in 12 of 36 rooms  ere observed in the following oking room one (1) of three (3) or dining room one (1) of three (3)		inspected for damage as needed by mainten  3. Maintenance staff was on 12-24-07 by Direct on monitoring of door lights for damage threfacility and the import maintenance.	e and repaired ance staff.  s in-serviced tor of Maintenance rs, tile and over bed oughout the tance of preventativ	
	arm chairs, and 2n six (6) chairs.  10. Damaged door areas: 2nd floor sideor, 1st floor day and 2nd floor day and 2nd floor day in 11. Overbed lights accumulation of du 136, 137, 139, 142 321, 337, and 378 observed.	d floor dining room three (3) of s were observed in the following moking room one (1) of one (1) room one (1) of two (2) doors, room one (1) of one (1) door.  were observed with an ust in the following rooms: 130, 1, 144, 145, 147, 237, 246, 312, in 14 of 36 resident rooms  c observed missing in the 2nd in one (1) of one (1) shower		<ul> <li>4. Monthly rounds will be maintenance staff and be reported in quarter?</li> <li>#11</li> <li>1. Over bed lights sited with dust in rooms 136, 137, 145, 147, 237, 246, 312, 378 were cleaned on 12-</li> <li>2. All other residents' room and were cleaned as need rounds will be conducted Environmental Services</li> </ul>	findings will ly CQI.  th accumulated 139, 142, 144, 321, 337 and -21-07.  as were inspected ded. Weekly d by the Director	12-28-07

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDINI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095015	B. WING_		12/06/2007
	ROVIDER OR SUPPLIER	EALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	12.00.2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLETION
F 253	spout was observed ust and debris in observed on the 3 conserved on the 3 conserved.  6. Soiled window following rooms: 145, 147, 207, 21 conserved: 145, 147, 207, 21 conserved: 145, 147, 207, 21 conserved: 15 conserved: 16 conserved: 17 conserved: 18 conserved: 18 conserved: 18 conserved: 18 conserved: 19 conserved:	ed soiled with an accumulation of one (1) of one (1) ice machine	F 253	<ol> <li>#10, #12 #13</li> <li>Damaged doors on 2<sup>nd</sup> floor room and 1<sup>nd</sup> floor day room during survey period was re 12-24-07. The broken tile in 2<sup>nd</sup> floor shower room will be by 1-28-08. The broken from the over bed light in rooms were repaired the same day of the over bed light panels in faction inspected for damage and reas needed by maintenance staff was in-set on 12-24-07 by Director of 1 on monitoring of doors, tile a lights for damage throughout facility and the importance of maintenance.</li> <li>Monthly rounds will be done maintenance staff and finding be reported in quarterly CQL.</li> <li>#11</li> <li>Over bed lights sited with account in room 130, 136, 137, 144, 145, 147, 237, 246, 312, and 378 were cleaned on 122</li> <li>All other residents' rooms were and were cleaned as needed. We rounds will be conducted by the Environmental Services to ensurompliance.</li> </ol>	citied paired on the pe repaired ont panel of 126 and 142 cited.  ms, and lity were epaired aff.  rviced Maintenance and over bed at the f preventative  by gs will  12-28-07  cumulated 139, 142, 321, 337 1-07.  cinspected Veekly birector

1/4/08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP	
		095015	B. WING	12/06/2007	
	ROVIDER OR SUPPLIER	EALTH CARE CENTER		TREET ADDRESS, CITY, STATE, ZIP CODE  1380 SOUTHERN AVE SE  WASHINGTON, DC 20032	12/06/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	CROSS- COMPLÉTION
F 278 SS=D	observed broken 12 resident rooms 14. Strong urine a the following area December 3, 200 2007 at 8:00 AM a December 3, 200 AM on December The above finding Employees #1, 2, the observations. 483.20(g) - (j) RE The assessment ir resident's status.  A registered nurse assessment with health professional A registered nurse assessment is co Each individual w assessment must that portion of the Under Medicare a willfully and know statement in a res civil money penal each assessment	at the 2nd floor.  It is of the over bed light was in rooms 126 and 142 in two (2) of a observed on the 1st floor.  Indical odors were detected in strooms 113 and 114 on 7 at 9:10 AM and December 4, and 1:40 PM, room 140 on 7 at 9:20 AM and room 219 at 8:55 4, 2007.  Its were acknowledged by 3, 4, 5, 6, 7, and 11 at the time of SIDENT ASSESSMENT  Indicate the appropriate participation of als.  It is must sign and certify that the impleted.  Indicate the accuracy of assessment.  Indicate the accuracy of assessment.  Indicate the analysis and the subject to a try of not more than \$1,000 for try or an individual who willfully and another individual to certify a	F 278	<ol> <li>Housekeeping staff were in-ser 12-20-07 on proper cleaning of lights.</li> <li>Findings will be monitored and in quarterly CQI.</li> <li>Rooms 113, 114, and 219 that cited for strong urine and fecal were cleaned, beds were washe privacy curtains were replaced 12-4-07</li> </ol>	reported  12-28-07  were l orders ed and i on  rders s needed.  vas rector dents'  keeping

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER  B. WING	06/2007
CAROLYN BOONE LEWIS HEALTH CARE CENTER  1380 SOUTHERN AVE SE WASHINGTON, DC 20032	
(X4) ID SUMMARY STATEMENT OF DEFICIENCES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 Continued From page 5 room observed on the 2nd floor.  13. The front panel of the over bed light was observed broken in rooms 126 and 142 in two (2) of 12 resident rooms observed on the 1st floor.  14. Strong urine and fecal odors were detected in the following areas: rooms 113 and 114 on December 4, 2007 at 8:00 AM and 1:40 PM, room 140 on December 4, 2007 at 9:20 AM and room 219 at 8:55 AM on December 4, 2007.  The above findings were acknowledged by Employees #1, 2, 3, 4, 5, 6, 7, and 11 at the time of the observations.  483.20(g) - (g) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment in ust sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment in a dispersion of the assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	12-28-07

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
AND FLAN O	CORRECTION	IBENTI TOATION NOMBER.	A. BUIL	DING	·	COMPLE	IED
		095015	B: WINC	3		12/0	6/2007
	ROVIDER OR SUPPLIER  N BOONE LEWIS H	EALTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL REGULATORY I IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 278	resident assessment penalty of not more assessment.  Clinical disagreer and false statemed.  This REQUIREM Based on observereview for one (1 determined that foode the Minimum resident for rehalt #20.  The finding included the foode the Minimum resident for rehalt #20.  The finding included the foode the Minimum resident for rehalt #20.  The finding included the foode the Minimum resident for rehalt #20.  The resident was approximately 11 contracted. Furth December 4, 200 PM and 4:00 PM approximately 8: 2:30 PM, and on approximately 8: observed with a subserved with a limitation in Randlimitation on one fingers; Section Rehabilitation/Resident Rehabilitation/Resident Resident Res	ment is subject to a civil money one than \$5,000 for each ment does not constitute a material ent.  ENT is not met as evidenced by: ation, staff interview and record of 27 sampled residents, it was acility staff failed to accurately m Data Set (MDS) for one (1) collitation/restorative care. Resident de:  accurately coded Resident #20 for torative care.  s observed on December 4, 2007 at 1:00 AM. Both hands were her observations were made on 07 at approximately 1:00 PM, 3:00 lt; on December 5, 2007 at 30 AM, 10:30 AM, 12:30 PM, and December 6, 2007 at 45 AM. The resident's was not hand splint or brace esident's quarterly MDS completed coded Section G4 "Functional age of Motion" for partial loss and side to hand including wrist or	F 2	278	F 278 483.20(g) - (j) RESIDENT ASSESSMENT  1. MDS Coordinator corrected r MDS on 12-12-07 for rehab/r Care. Rehab screen was requival-11-07 and complete on 12-The recommendations was for proctors and range of motion.  2. All other residents identified Restorative/rehab care record Been reviewed for PMD order Correct implementation and Documentation.  3. MDS Coordinator was in-ser 12-06-07 on the correct coding restraints and restoratative car DON.  4. Random audits will be done be managers of residents with specific to ensure proper coding on M and PMD orders and finding reported in quarterly CQI.	restorative lested on 12-07 and r palm  with s have ers and  viced on ng for re by the  ry unit lints	12-28-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SL COMPLE	
			A. BUILDIN	<u> </u>	•	
	<u>.</u>	095015	B. WING		12/0	06/2007
	OVIDER OR SUPPLIER	ALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE VASHINGTON, DC 20032		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 278	coded for full loss Section P3 "Nursir Care" was coded for full loss Section P3 "Nursir Care" was coded for full loss section P3 "Nursir Care" was coded for full loss of the clirithe use of a splint.  A face-to-face interest Employees #3 and approximately 9:00 Employees #3 and his/her bed with bith hands. Employees information on the Rehabilitation/ Resident's record a Nursing Rehabilitation/ Resident was inacceded to the code of the	ber 5, 2007 Section G4 was and limitation on both sides; and and Rehabilitation/Restorative or splint or brace assistance.  Inical record lacked an order for or brace for the resident.  Inview was conducted with last on December 6, 2007 at last of AM. The surveyor and last of the surveyor and last and 15 were unable to find resident in the Nursing storative Care book. The last older lacked evidence of any tion/ Restorative Care services.  Is acknowledged that the surately coded for Nursing storative Care services. The last of th	F 278			
F 279 SS=D	PLANS A facility must use develop, review ar comprehensive plate the facility must deplan for each residual plan fursing, a needs that are ide assessment.  The care plan must residual plan for each residual	the results of the assessment to a revise the resident's an of care.  evelop a comprehensive care lent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive	F 279			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095015	B. WING		12/0	6/2007
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	LTH CARE CENTER	\$	STREET ADDRESS, CITY, STATE 1380 SOUTHERN AVE SE WASHINGTON, DC 200		
(X4) 1D PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE	PLAN OF CORRECTION ACTION SHOULD BE CROSS- E APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	psychosocial well-b and any services the under §483.25 but a resident's exercise including the right to §483.10(b)(4).  This REQUIREMENT Based on observation interview for three (was determined that care plan with approach (1) resident recone (1) resident recone (1) resident with resident receiving a #16, 20 and F2.  The findings included 1. Facility staff failed goals and approach psychotropic medical The November 200 signed November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 10.5 mg one tab by resident receiving a with the service of the November 1	physical, mental, and eing as required under §483.25; at would otherwise be required are not provided due to the of rights under §483.10, orefuse treatment under  IT is not met as evidenced by: ons and record review and staff (3) of 24 sampled residents, it t facility staff failed to develop a opriate goals and approaches for eiving psychotropic medication, in contractures and one (1) inticoagulant therapy. Residents et did to develop a care plan with the set for Resident #16 receiving a	F 27	COMPREHENS: #16, #20, #F2  1. Unit Managers for resident #16 goals on 12-04 medication. A contractures. A for resident F2 goals on 12-04 contractures. A for resident F2 goals on 12-5-0 therapy.  2. All other resident psychotropic in contractures, a therapy records care plans were MDS Coordin was in-service plan developing psychotropic in anticoagulant with contractures.  4. Random audit Unit Managers records for care	developed a care plan 6 with approaches and -07 for psychotropic care plan was developed 9 with approaches and 4-07 for a care plan was developed with approaches and 97 for anticoagulant ents identified on nedication, and anticoagulant s were reviewed and developed as needed.  8, DON and nator ed on 12-21-07 on care nent for residents on medication, residents on therapy and residents ares by the Educator.  8 will be conducted by 8 to monitor residents' e plan development on uring care plan and PRN. be monitored in	12-28-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095015	B: WIN	e		12/0	6/2007
	N BOONE LEWIS HE	ALTH CARE CENTER	•	138	T ADDRESS, CITY, STATE, ZIP CODE O SOUTHERN AVE SE SHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL) REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 279	approaches for Repsychotropic medical A face-to-face interpolic medical A face-to-face further policy medical A face-to-face-t	eloped with goals and sident #16's use of a cation.  rview was conducted with ecember 4, 2007 at 3:50 PM. ged that a care plan was not use of a psychotropic medication. viewed December 4, 2007.  ed to initiate a care plan for contractures in both hands.  observed on December 4, 2007 at 00 AM. Both hands were robservations were made on at approximately 1:00 PM, 3: 00 on December 5, 2007 at 00 AM, 10:30 AM, 12:30 PM, and becember 6, 2007 at 50 AM. The resident's hands were sident's quarterly MDS completed ded Section G4 "Functional e of Motion" for partial loss and ide to hand including wrist or	F:	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		G	COMPLET		
		095015	B. WIN	IG		12/0	6/2007	
•	OVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1380 SOUTHERN AVE SE  WASHINGTON, DC 20032				
(X4) ID PREFIX TAG			ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 279	care plan was initial approaches for the both hands.  A face-to-face intent Employee #3 on Deapproximately 2:45 a care plan was not both hands. The received and approach anticoagulant theral A review of Resider	There was no evidence that a red with appropriate goals and resident with contractures in view was conducted with cember 6, 2007 at PM. He/she acknowledged that initiated for the contractures in cord was reviewed December 6, d to develop a care plan with res for Resident F2 receiving by.	F	279				
F 280 SS=D	November 24, 2007 tab p.o. [by mouth] vein thrombosis]."  A review of the care 6, 2007, revealed the approaches for antional A face-to-face intended by the complex of the care 10 to 10 t	view was conducted with cember 6, 2007 at 1:50 PM. led that a care plan was not bagulation therapy. The record	F	280				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDIN		LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLET		
		095015	B. WING		12/0	6/2007
	OVIDER OR SUPPLIER	EALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 280	within 7 days after comprehensive as interdisciplinary to physician, a regist the resident, and disciplines as deterand, to the extent the resident, the relegal representation revised by a team assessment.  This REQUIREMINE Based on record of the findings included facility staff failed plan for falls.  The findings included resident fell on Justin September 4 and The resident was on July 25, 2007, result of the screen There was no evicagoals and approach	care plan must be developed rethe completion of the ssessment; prepared by an eam, that includes the attending tered nurse with responsibility for other appropriate staff in ermined by the resident's needs, practicable, the participation of resident's family or the resident's ve; and periodically reviewed and of qualified persons after each review and staff interview for one residents, it was determined that to update Resident #19's care de:  The series of the physical therapist of the complete of the com	F 2	F 280 483.10(k)(2) COMPREHENSIVE CA  1. Unit Manager updated Care plan on 12-6-07 in Additional goals and a fall prevention and reherequested on 12-06-0  2. All other residents idea care plans were review updated with additional approaches if needed.  3. Unit Managers were in 12-24-07 for updating for residents with fall goals and approaches  4. Unit Managers will do audits for care plan up monitor in quarterly	I resident #19 for approaches for ab screen was 07.  Intified for falls wed and were al goals and  In-serviced on g care plans is for additional by the Educator.  O random chart odates and will	12-28-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	BEINT IOATION NOWBEN.	A. BUILDING	<u> </u>	OOM LETED
		095015	B. WING		12/06/2007
	NOVIDER OR SUPPLIER	ALTH CARE CENTER	13	EET ADDRESS, CITY, STATE, ZIP CODE 880 SOUTHERN AVE SE VASHINGTON, DC 20032	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES OF BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN.OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	E CROSS- COMPLÉTION
F 280	A face-to-face inter Employee #8 on De	view was conducted with ecember 6, 2007 at 5:30 PM.	F 280		
	He/she acknowledge approaches were n	ged that additional goals and lot initiated after the ls. The record was reviewed			
F 281 SS=D	The services provide	MPREHENSIVE CARE PLANS  ded or arranged by the facility lonal standards of quality.	F 281	F 281 483.20(k)(3)(I) COMPREHENSIVE CARE PI 共り、 は 2 1. Unit Manager obtained orders PR/INR for resident #4 and F	for 1 on
	Based on staff inte (1) of 27 sampled r supplemental resid facility staff failed to monitor PT/INR (Pr International Norma residents receiving manufacturer's receiving manufacturer's receiving to the m "According to the m "Accoptable intervatime)/INR (Internations are 4 weeks after a state determined" from the squib.  1. Facility staff failed obtain PT/INR laborates.	NT is not met as evidenced by: rview and record review for one esidents and one (1) ent, it was determined that o obtain physician orders to rothrombin Time and alized Ratio) levels for two (2) Coumadin(Warfarin) as per ommendations. Residents #4 and e: anufacturer's recommendations, als for PT (Prothrombin tional Normalized Ratio) normally within the range of 1 to ble dosage has been the web-site www.bristol-myers- ed to obtain physician's orders to oratory (lab) tests for Resident #4. er Sheet [POS] and Plan Care		<ol> <li>12-5-07 and labs were drawn of 12-6-07 and labs were within limits.</li> <li>All other resident identified of anticoagulants records were reviewed and corrected as needs.</li> <li>Licensed staff was in-serviced 12-24-07 on anticoagulant therapy policy and procedures unit managers.</li> <li>Random chart audits will be do by Unit Managers for residents anticoagulant therapy to ensure lab orders have been followed PMD orders and monitored in Quarterly CQI.</li> </ol>	normal  neded. on by one s on

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SU COMPLET	
		·	A. BUII	_DING	· · ·	,	
		095015	B. WIN	G		12/0	6/2007
	ROVIDER OR SUPPLIER  N BOONE LEWIS HE	ALTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 281	Continued From pa	•	F	281			
		007 and October 30, 2007 lin 5 mg po [by mouth] qd ood thinner."					
		S for September, October and vealed that there were no for PT/INR.					
	PT/INR values wer and were within ex	ident's record revealed that e obtained on August 15, 2007 pected limits. There was no tional PT/INR values were drawn 007.					
	December 2007 M revealed that Warf	ptember, October, November and edication Administration Records arin (Coumadin) 5 mg was that it was administered] daily.					
	Employee #2 on D He/she acknowled order to monitor th	rview was conducted with ecember 4, 2007 at 3:00 PM. ged that there was no physician e PT/INR level since August 15, was reviewed December 4, 2007.					
	2. Facility staff faile for PT/INR lab test	ed to obtain a physician's order s for Resident F1.					
	and dated October 2.5 mg po [by mou thinner." There was studies included in	er Sheet and Plan of Care signed 22, 2007 revealed, "Coumadin th] qd [everyday] for a blood as no order for PT/INR laboratory the October, November and hysician's Order Forms.					
	A review of the Oc	tober, November and					

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

•	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		095015	B. WING		12/06/2	:007
	OVIDER OR SUPPLIER	EALTH CARE CENTER	S	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	ILD BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From		F 30	F 309 483.25 QUALITY OF CARE		
		iled to monitor Resident #3's ohysician's orders.		#1 & #3 Resident #3, #16	h.l.s.d	
	physician's order and renewed on (monthly orders) October 25, 2007	dent #3's record revealed a initially dated November 13, 2006 the physician's order forms August 30, September 22 and that directed, "Monitor behavior q and abusive language."		1. Unit Manager obtained a Monitoring order for res #3 on 12-20-07 and obta A behavior monitoring re sheet for Resident #16 or  2. All other residents ident	ident sined ecord/ n 12-05-07.	
	resident's behavi and abusive lang 2007. According	idence in the record that the for had been monitored for kicking guage for September and October, to the November 2007 Treatment		psycho tropic's therapy were reviewed for behav Orders and records were Needed.	vior monitor	
	was monitored e 20, 2007. Hand next to the behave (discontinue). To	vecord (TAR) the resident's behavior very shift from November 1 through written on the November 2007 TAR vior monitoring order was " D/C " here was no physician's order to behavior monitoring.		<ul> <li>3. Licensed staff was in-se</li> <li>On psychotic orders and</li> <li>Of behavior monitoring</li> <li>By Unit Managers on 12</li> <li>4. Random MAR audits wi</li> </ul>	d accuracy process. 2-27-07.	
	Employee #1 on He/she acknowl monitoring for A 2007 and that the discontinue the	terview was conducted with December 4, 2007 at 3:30 PM. edged that there was no behavior ugust, September and October tere was no physician's order to behavior monitoring in November and was reviewed December 4, 2007.		By unit managers and find Monitored in quarterly Community  #2 Resident #4  1. Charge nurse obtained a order for resident #4 on	CQI.	12-28-07
	prior to performi foot.	ailed to obtain a physician's order ng a treatment to Resident #4's left on of a dressing change		2. All other residents ident with wound care, record reviewed for treatment of corrected as needed.	s were	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095015	B. WIN	IG <u></u> _		12/0	6/2007
	ROVIDER OR SUPPLIER	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 309	observation conduct 11:15 AM, it was observation to conduct 11:15 AM, it was observation was wrapped in December 3, 2007 and dressing change was according to the Oct Administration Record to the left foot from Control of the left foot from Control of the left foot from Control of the left foot dressing was do December 2, 2007.  Employee #11 was a dressing to the left for have an order to adressing. Once the substance was observation was observationally and the substance was observationally and the substance was observationally and the substance was no odor of the physical of the physical of the physical observation was no odor of the physical observation.  A review of the physical observation of the physical observation of the physical observation of the physical observation.  The November 2007 signed November 15 observations of the physical observation.	served that Resident #4's left gauze that was dated nd initialed [indicating that the s performed].  sober 2007 Treatment rd, Panafil ointment was applied October 1 through 31, 2007. In the series of the process of t	F	309	<ol> <li>Licensed staff was in-serviced 12-26-07 by DON on obtaining treatment orders for all wound.</li> <li>Unit Managers will do random chart audits for treatment order and findings will be reported in quarterly CQI.</li> </ol>	ig ds. 1 ers	12-28-07

equeter 1/4/28

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLET	
	<del></del>	095015	B. WING		12/0	6/2007
	OVIDER OR SUPPLIER	ALTH CARE CENTER	1;	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
F 309	Medication Adminical Clonazepam 0.5 n was given daily.  A review of the reception of the reception of the reception of the nut the resident had a agitation.  A face-to-face interest employee #3 December 4, 2007  4. Facility staff fair bilateral hand confident was not monitored December 4, 2007  4. Facility staff fair bilateral hand confident was not monitored December 4, 2007  4. Facility staff fair bilateral hand confident was not monitored December 4, 2007  4. Facility staff fair bilateral hand confident was not monitored December 4, 2007  4. Facility staff fair bilateral hand confident was not monitored December 4, 2007  4. Facility staff fair bilateral hand confident was not monitored December 4, 2007  4. Facility staff fair bilateral hand confident was not monitored December 4, 2007  5. A review of the reserve of t	ovember and December 2007 istration Record revealed that ing was initialed [indicating that it cord lacked evidence that havior was being monitored for ecember 2007.  rsing notes lacked evidence that ny documented episodes of  erview was conducted with ember 4, 2007 at 3:50 PM. Iged that the resident's behavior i. The record was reviewed  determined to assess Resident #20 with tractures.  observed with bilateral contracted her 4, 2007 at approximately 11:00 of PM, and 4:00 PM; December 5, hately 8:30 AM, 10:30 AM, 12:30 and on December 6, 2007 at	F 309	#4 Resident #20  1. MDS Coordinator correcter resident #20 MDS on 12-1 for rehab/restorative Care. Rehab screen was requeste 12-11-07 and complete on and the recommendations for palm protectors and rate of motion. Unit Manager a care plan for resident #2 approaches and goals on for contractures  2. All other residents identified Restorative/rehab care, received for PMD or correct implementation and documentation and care plate developed and updated with approaches and goals.  3. MDS Coordinator and Unit Managers was in-serviced of 12-06-07 on the correct codis rehab/restorative care and care plan development for contract by the DON.  4. Random audits of residents we splints and records will be reviewed for contracture care plan development and finding will be reported in quarterly	d on 12-12-07 was nge developed 0 with  d with ords have ders and ns  n ng for re	12-28-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
i		0 <del>95</del> 015	B. WING		12/06/2007	
	OVIDER OR SUPPLIER	LTH CARE CENTER	1;	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE DI	BE CROSS- COMPLETION	
F 309	A review of the Nove Medication Administ Clonazepam 0.5 mg was given] daily.  A review of the reco Resident #16's beha November and Dece A review of the nurs the resident had any agitation.  A face-to-face intervement of the management of the nurs the resident had any agitation.  A face-to-face intervement of the resident was not monitored. December 4, 2007.  4. Facility staff failed bilateral hand contrained on December AM, 1:00 PM, 3:00 FM, 2007 at approximate PM, and 2:30 PM; and approximately 8:45 A review of the resident was obtained in Range limitation on one side completed November full loss and limitation.	ember and December 2007 ration Record revealed that was initialed [indicating that it and lacked evidence that avior was being monitored for ember 2007.  Ing notes lacked evidence that a documented episodes of  Inew was conducted with inber 4, 2007 at 3:50 PM. Indicated that the resident's behavior The record was reviewed  Indicated that the resident's behavior The record was reviewed	F 309	1. MDS Coordinator correcte resident #20 MDS on 12-1 for rehab/restorative Care. Rehab screen was requeste 12-11-07 and complete on and the recommendations for palm protectors and rate of motion. Unit Manager a care plan for resident #2 approaches and goals on for contractures  2. All other residents identifies Restortative/rehab care, received for Primary doctors orders and correct implementation and docume and care plans developed at with approaches and goals.  3. MDS Coordinator and Unit Managers was in-serviced of 12-06-07 on the correct codi rehab/restorative care and care plan development for contractors by the DON.  4. Random audits of residents with approaches and records will be reviewed for contracture care plan development and findit will be reported in quarterly	d on 12-12-07 was unge developed 0 with  d with ords have Medical many for ure ctures  with  re ungs	
		· · · · · · · · · · · · · · · · · · ·		·		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	١.	B.WING		12/06/2007	
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 309	November 6, 2007. care plan was initiat approaches for the both hands.  There was no evide staff initiated an ass resident's bilateral has a seried and a seried	There was no evidence that a sed with appropriate goals and resident with contractures in the record that facility dessment of the change in the land range of motion.  The was conducted with the was conducted with the was conducted with the was conducted after a change in the late record was reviewed to obtain a PT/PTT for physician's orders.  The was reviewed to obtain a PT/PTT for physician's orders.  The was reviewed to obtain a PT/PTT for physician's orders.  The was reviewed to obtain a PT/PTT for physician on October 27, 2007 the was all the order dated October 27, 2007 the was all	F	309	#5 & 6 Resident 21 and F2  1. Unit Manager obtained in Scheduled blood draw for On resident #21 on 11 and PT/PTT on resident #F2 on 12-5-  2. All other residents identifit with lab test orders for PT and PT/PTT records have reviewed and test comple ordered.  3 Licensed staff was in-served 12-24-07 by DON on the importance of obtaining lab draws and in the Unit Managers if test  4. Residents receiving anticoact therapy records will be audic compliance and findings reportantly COI.	or PT/INR 1-12-07 07. ed /INR been ted as riced on  forming is not done. gulant ted for	12-28-07

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WH			12/06/2007	
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032	120	672007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAC	1	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 309	PT/PTT values were October 29, 30, 31 at The PT/PTT for Nov approximately 10 timesident was sent to evaluation of the elecellulitis to both lower A face-to-face interved Employee #1 on Determination of the elecellulitis to both lower A face-to-face interved Employee #1 on Determination of the elecellulitis to both lower Employee #1 on Determination of the elecellulitis to both lower Employee #1 on Determination of The Interved Employee #1 on Determination of Employee #2 on Determination of Employee #3 on Determination of Employee #3 on Determination of Employee #4 on	e within the expected ranges for and November 1 and 2, 2007. ember 12, 2007 was nes the expected value. The the hospital for further vated PT and concurrently er extremities.  iew was conducted with cember 5, 2007 at 4:00 PM. ed that the November 5, 2007 ne. The record was reviewed do to obtain a PT/PTT (Partial e) lab tests for Resident F2 as cian.  ian's order dated November 21 er 24, 2007 directed, "PT/PTT 07 and q [every] month".  Iler form dated November 26, est requested- PT, PTT "I were marked done [indicating n].	F	309			
		n PT/PTT labs before					

PRINTED: 12/19/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095015	B. WING		12/0	6/2007
	OVIDER OR SUPPLIER	EALTH CARE CENTER	s	TREET ADDRESS, CITY, STATE, ZIP COD 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE
F 281	revealed that Wa initialed [indicating A review of the report PT/INR laborator from the hospital A face-to-face into Employee #8 on He/she acknowless	Medication Administration Records rfarin (Coumadin) 2.5 mg was g that it was administered] daily.  ecord revealed that there were no y values since the resident's return on October 22, 2007.  erview was conducted with December 6, 2007 at 10:45 AM. edged that there was no physician Warfarin therapy. The record was	F 28	31		
F 309 SS=D	provide the nece maintain the high and psychosocia	OF CARE  Just receive and the facility must ssary care and services to attain or nest practicable physical, mental, il well-being, in accordance with the assessment and plan of care.	F 30	09		
	Based on observeriew for four (4) supplemental facility staff failed residents, failed administering at obtain laboratory one (1) resident and administer of	vations, staff interviews and record by of 27 sampled residents and two I residents, it was determined that d to: monitor behaviors for two (2) to obtain a physician's order prior to treatment for one (1) resident, v tests for two (2) residents, assess with bilateral hand contractures, by the contractures, by the contractures of the contrac				

Event ID:898Z11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-	<u></u> .	095015	B. WING		12/06/2007	· ·
	ROVIDER OR SUPPLIER	EALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPL	
F 309	reviewed December 7. Facility staff fail oxygen per the phonon December 6, 2 was observed that with a nasal cannic [oxygen] concentre Employee #3 in the observation immediate concentrator into untoward effects.  A review of the Nosigned November "O2 at 4L/min via A face-to-face into December 3, 200 Employee #3. He concentrator was oxygen per the phonon 483.25(h) ACCIDITATE The facility must even is possible; and essupervision and a accidents.	de to administer Resident F3's hysician's order.  2007 at approximately 9:30 AM it to Resident F3 was lying in bedula in his/her nose. The O2 ator was not plugged into the wall, he room at the time of the diately plugged the oxygen the wall. Resident F3 suffered no overber 2007 physician's order 15, 2007 revealed, nasal cannula."  Perview was conducted on at approximately 9:30 AM with she acknowledged that the O2 unplugged and not delivering the hysician's order. ENTS AND SUPERVISION ensure that the resident hazards as ach resident receives adequate ssistance devices to prevent	F 309	#7 Resident #F3 1. Unit Manager plugged the 02 concentrator into the wall outle on 12-6-07.  2. All other residents' identified 02 therapy units were checked proper operation and corrected needed.  3. All staff was in-serviced on the importance of proper function of 02 concentrators and 02 therapy on 12-24-07 and 12-26-07 by the DON.  4. Random and frequent checks for 02 concentrators function will be done by nursing staff ar findings will be reported in quarterly CQI.	on I for I as	8-07
	Based on observa	ENT is not met as evidenced by: ations during the survey period, it not facility staff failed to				

CENTER	13 FOR MEDICARE	X MICDIOAID SCRAIGES				OIVID IVO.	0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. Win	IG		12/06	5/2007
	OVIDER OR SUPPLIER	LTH CARE CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE NASHINGTON, DC 20032	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
F 323	by: ointments locate broken prong on a remissing wheel on a failed to completely strips hanging in reswash station in the libetween the rooms were located in the lobserved in the presson of the street of the failed of the lobserved in the presson of the street of the lobserved in the presson of the lobserved in the bedside in Rewas prescribed for FC almoseptine was posserved the bed at the time of the lobserved in th	ee environment as evidenced d at a resident's bedside, esident's electric bed plug, resident's bed, window that close in a resident's room, pest idents' rooms, lack of an eye aundry and a blocked door where the washers and dryers aundry. These findings were sence of Employees #1, 2, 3, 4, and Calmoseptin were observed sident #20's room. The Panafil Resident #7 and the prescribed for Resident #16.  Isident's electric bed plug in missing. The resident was in of the observation.  Isident's bed was observed A. The resident was in the bed servation.  Im 323 was observed briskly blew into the resident's room, able to completely close. The complain of being cold,	F	323	F 323 483.25(h) F 323 483.25(h) ACCIDENTS AND SUPERVIS #1  1. Medication was removed from At time of observation for res  2. All other residents bedside were for medication inappropriately medications were removed as n  3. In-service was given to license on 12-24-07 for proper proceed administration by DON and Un Managers.  4. Random audits will be perform Educator and findings will be Reported in quarterly CQI.  #2, #3, #4  1. The bed with the prong missing in room 312A was immediately removed and replaced. The mis wheel on bed 223A was placed bed the day of the survey. The was repaired on the same day or observation.  2. All other residents' rooms were to ensure beds were compliant a windows were opening and clos properly.	n bedside ident #20.  re checked placed and reeded.  d staff lure of nit  red by  ssing on window f	12-28-07

NAME OF PROVIDER OR SUPPLER  CAROLYN BOONE LEWIS HEALTH CARE CENTER  SUMMANY STATEMENT OF DEPICIENCES  (IRACH DEPICIENCY MAST BE PRECEDED BY TALL REGULATORY TAG THE PROVIDER'S FLAM OF CORPRECTION CONCESS ENTRY WITHOUT SHEET ADDRESS, CITY, STATE, 2IP CODE 1330 SOUTHERN AVE SE WASHINGTON, DC 20032  F 323 Continued From page 21 maintain a hazard free environment as evidenced by, cintiments located at a resident's bedside, broken prong on a resident selectic bed plug, missing wheel on a resident's bed, window that failed to completely close in a resident's room, pest strips hanging in resident's rooms, tack of an eye wash station in the laundry and a blocked door between the rooms where the washers and dryers were located in the isundry. These findings were observed in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11.  The findings include:  1. Panafil ointriment and Calmoseptin were observed at the bedside in Resident's electric bed plug in 312A was observed missing in room 223A. The resident was in the bed at the time of the observation.  3. The wheel of a resident's electric bed plug in 312A was observed missing in room 223A. The resident was in the bed at the time of the observation.  4. The curtain in room 323 was observed missing in room 223A. The resident was in the bed at the time of the observation.  4. The curtain in room 323 was observed briskly moving as the wind blew into the resident's room. The window was unable to completely close. The Resident F4 did not complete of being cold, however complained of the wind.  5. Pest strips were observed hanging from the ceiling above residents' beds in rooms 313 and 337.  6. There was no eye wash station observed in the	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU A. BUILE	ULTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLET	
STREET ADDRESS, CITY, STATE, 2IP CODE 1398 SOUTHERN AVE SE   1398	-	<del></del>	095015	B:-WING	)	. 12/0	6/2007
F 323 Continued From page 21 maintain a hazard free environment as evidenced by: ointments located at a resident's bedside, broken prong on a resident's bed, window that failed to completely close in a resident's room, lack of an eye wash station in the laundry and a blocked door between the rooms where the washers and dryers were located in the laundry. These findings were observed in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11.  The findings include:  1. Panafil ointment and Calmoseptin were observed at the bedsiden in Resident's electric bed plug in 312A was observed missing. The resident was in the bed at the time of the observation.  3. The wheel of a resident's bed was observed missing in room 223A. The resident was in the bed at the time of the observation.  4. The curtain in room 323 was observed missing in room 223A. The resident's room. The window was unable to completely close. The Resident F ad do not complain of being cold, however complained of the wind.  5. Pest strips were observed hanging from the celling above residents' beds in rooms 313 and 337.		-	LTH CARE CENTER		1380 SOUTHERN AVE SE	•	
maintain a hazard free environment as evidenced by: ointments located at a resident's bedside, broken prong on a resident's bedside, broken prong on a resident's bed, window that failed to completely close in a resident's room, pest strips hanging in residents' rooms, lack of an eye wash station in the laundry and a blocked door between the rooms where the washers and dryers were located in the laundry. These findings were observed in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11.  The findings include:  1. Panafil ointment and Calmoseptin were observed at the bedside in Resident #20's room. The Panafil was prescribed for Resident #16.  2. The prong of a resident's electric bed plug in 312A was observed missing. The resident was in the bed at the time of the observation.  3. The wheel of a resident's bed was observed missing in room 223A. The resident was in the bed at the time of the observation.  4. The curtain in room 323 was observed briskly moving as the wind blew into the resident's room. The window was unable to completely close. The Resident F4 did not complain of being cold, however complained of the wind.  5. Pest strips were observed hanging from the ceiling above residents' beds in rooms 313 and 337.	PREFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION S	SHOULD BE CROSS-	
	F 323	maintain a hazard from by: ointments located broken prong on a radiced to completely strips hanging in resumble wash station in the located in the observed in the observed in the presson, 7, and 11.  The findings included the findings included the bedside in Resumble was prescribed for findings call the bed at the time of the observed the bed at the ti	ree environment as evidenced ed at a resident's bedside, resident's electric bed plug, resident's bed, window that close in a resident's room, pest sidents' rooms, lack of an eye laundry and a blocked door where the washers and dryers laundry. These findings were sence of Employees #1, 2, 3, 4, e:  and Calmoseptin were observed esident #20's room. The Panafil Resident #7 and the prescribed for Resident #16.  esident's electric bed plug in a missing. The resident was in the observation.  esident's bed was observed BA. The resident was in the bed observation.  em 323 was observed briskly blew into the resident's room. The complain of being cold, d of the wind.  ebserved hanging from the ents' beds in rooms 313 and 337.	F 3	#5  1. The pest strips that were 313 and 337 were removed for pest strips and were reded.  3. Staff were in-serviced or placing unauthorized art in the facility and follow regulations by the Unit 4. Unit Managers will make To ensure units are free or serviced or pest strips are free or ensure units are free or mested to the service of	e for monitoring by the Director  ive maintenance onthly and ad in quarterly  e cited in rooms are cited in mediately.  In swere checked removed as  in 12-21-07 on ticles/products are manager.  It is removed as are manager.  It is removed as are manager.  It is removed as are manager.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	· .	095015	B. WING		12/06/2007	
	OVIDER OR SUPPLIER	LTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS- COMPLÉTION	
F 323	by: ointments locate broken prong on a remissing wheel on a failed to completely strips hanging in reswash station in the libetween the rooms were located in the I observed in the presson of a remissing in room 223 at the time of the observed the was prescribed for FC almoseptine was observed the bed at the time of the observed at the time of the observed at the time of the observed was unapplied to the property of the proof of	ee environment as evidenced d at a resident's bedside, esident's electric bed plug, resident's bed, window that close in a resident's room, pest idents' rooms, lack of an eye aundry and a blocked door where the washers and dryers aundry. These findings were sence of Employees #1, 2, 3, 4, and Calmoseptin were observed sident #20's room. The Panafil Resident #7 and the prescribed for Resident #16.  Sident's electric bed plug in missing. The resident was in of the observation.  Sident's bed was observed A. The resident was in the bed servation.  m 323 was observed briskly blew into the resident's room, able to completely close. The complain of being cold,	F 323	#6  1. The eyewash station in the laun Was repaired on 12-21-07.  2. All other eyewash stations were by maintenance staff to ensure and were repaired or replaced and were repaired or replaced as a Maintenance staff was in-serviced 12-24-07 by the Director of Maintenance of the eyewash stations to ensure compliance.  4. Monthly rounds will be done by maintenance staff to monitor compliance.	e inspected compliance as needed. ced on intenance	
	6. There was no eye	wash station observed in the		of all eyewash stations and find be reported to quarterly CQI.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		095015	B, WING	· · · · · · · · · · · · · · · · · · ·	12/06	3/2007	
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER		LTH CARE CENTER	\$	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	12/00	/06/2007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE	
F 323	maintain a hazard fr by: ointments located broken prong on a r missing wheel on a failed to completely strips hanging in reswash station in the between the rooms were located in the observed in the presson of the findings included the findings included the findings included the findings included the prescribed for findings included the bedside in Reswas prescribed for findings included the bedside in Reswas prescribed for findings included the bedside in Reswas prescribed for findings in room of the bed at the time of the observed the bed at the time of the observed the bedside in room 223 at the time of the observed the bedside in room 223 at the time of the observed the bedside in room 24. The curtain in room moving as the wind The window was un Resident F4 did not however complained to the prescribe the strips were ceiling above resides	ree environment as evidenced ed at a resident's bedside, resident's electric bed plug, resident's bed, window that close in a resident's room, pest sidents' rooms, lack of an eye laundry and a blocked door where the washers and dryers laundry. These findings were sence of Employees #1, 2, 3, 4, es:  and Calmoseptin were observed esident #20's room. The Panafil Resident #7 and the prescribed for Resident #16.  esident's electric bed plug in a limissing. The resident was in the observation.  esident's bed was observed esident's bed was observed esident's bed was observed esident's room.  esident's lectric bed plug in the observation.  esident's bed was observed esident's room.  esident's bed was observed briskly blew into the resident's room.  and 323 was observed briskly blew into the resident's room.  able to completely close. The complain of being cold,	F 32	#7  1. The laundry room door during survey as not being it was blocked by a large and other debris were incorrected.  2. All other doors in the lanchecked to ensure compared to ensure compared in the conference of the conference	ing open because the floor mat, bins in mediately aundry were obtained and as needed.  In 12-21-07 in door that in ming and in ming and intal Services.  In the formula of the material services and findings	12-28-07	

l eyustur 1/4/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
						4
		095015	B. WING		12/0	6/2007
	OVIDER OR SUPPLIER	ALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 386 SS=D	eye wash faucet, by and the eye wash faucet, by and the eye wash faucet, by and the eye wash faucet and the drying to be opened. The washing area was and other debris.  Employees #1, 2, 3 acknowledged the observations.  483.40(b) PHYSIC  The physician must program of care, in treatments, at each of this section; writt at each visit; and sexception of influer polysacchande vacadministered per pafter an assessment.  This REQUIREME  Based on observative for two (2) of determined that the failed to include a condition and addrives ident. Resident.	e #5 stated that the sink had an out was repaired a few weeks ago faucet was not replaced.  the door between the washing grae ain the laundry was unable other side of the door in the blocked by a large floor mat, bins  3, 4, 5, 6, 7, and 11 above findings at the time of the  IAN VISITS  It review the resident's total actuding medications and in visit required by paragraph (c) e, sign, and date progress notes aign and date all orders with the initial and pneumococcal occines, which may be any hysician-approved facility policy and for contraindications.  INT is not met as evidenced by:  Ition, staff interview and record of 27 sampled residents, it was a physician's progress notes review of one (1) resident's skin ess hand contractures for one (1) is #4 and 20.	F 386	F 386 483,40 PHYSICIAN VISITS	nts' ance of ir  d with ed and cal mpliance.	
		in the progress notes.		quarterly CQI.		12-27-07

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/19/2007 I APPROVED ): 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		096015	e. Wi	NG_	<u> </u>	12/0	6/2007
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER				}	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 323	eye wash faucet, bu	ge 22 #5 stated that the sink had an it was repaired a few weeks ago nucet was not replaced.	F	323	3		
	area and the drying to be opened. The o	e door between the washing area in the laundry was unable ther side of the door in the locked by a large floor mat, bins					
F 386 SS=D	observations.	bove findings at the time of the	F	386	F 386 483.40 PHYSICIAN VISITS Resident #4 and # 20 #1, & #2		
·	program of care, inc treatments, at each of this section; write at each visit; and sig exception of influent polysaccharide vaccadministered per ph	review the resident's total duding medications and visit required by paragraph (c), sign, and date progress notes on and date all orders with the za and pneumococcal sines, which may be ysician-approved facility policy to roontraindications.			1. Unable to correct residents #4 and #20 physicians progress notes and physicia were notified of their reside with wounds and hand con the importance of documen wounds and hand contractu their progress notes.	uns ent's atractures ating M	11/1/28
	Based on observation review for two (2) of determined that the failed to include a re-	T is not met as evidenced by: on, staff interview and record 27 sampled residents, it was physician's progress notes eview of one (1) resident's skin ss hand contractures for one (1) #4 and 20.			<ol> <li>All other residents identified wounds charts were reviewed a list was given to the Media Director to ensure future confidence of the medical Director in-services medical staff to include wound documentation in the progress notes on 12-27-07.</li> </ol>	ed and cal mpliance. ed	
		ed to include a review of the progress notes.			<ol> <li>DON will monitor physician wound documentation and finding will be reported in quarterly CQI.</li> </ol>	<b>ì</b>	12-27-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015				12/06/2007	
	ROVIDER OR SUPPLIER		<b>I</b>	13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032	12/0	6/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 386	revealed, "Location: 27, 2007, Stage I, Munopened discolorar September 5, 2007, cm, unopened discolorated october 3, 2007, Stage II, Munopened discolorated october 3, 2007, Stage II, Munopened discolorated october 3, 2007, Stage III, Stage II	Report" form for Resident #4 Left foot side posterior; August leasurement-5 x 5 cm, tion; Stage I, Measurement-4.2 x 5 loration fading, purplish; age-I, Measurement- 4 x 3 cm; ue, no odor/drainage. "  " form for Resident #4 revealed, fied: August 21, 2007, where ght Ankle, Measurement- 2.5 x unable to read] and dry; o description documented; Right Ankle 1.8 x 1 cm, no th with granulation; ght Ankle, Measurement- 2 x 2 on with dry [unable to read] no sician's progress notes dated October 30, 2007 lacked hysician addressed the liew was conducted with cember 4, 2007 at 3:00 PM. and that the physician's progress ce that the areas to the left foot were addressed. The record	F	386			
		ed to address Resident #20's					
		served on December 4, 2007 at AM, 1:00 PM, 3:00 PM					

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION	(X3) DATE SUI	
AND FLAIR OF	CONNECTION	SERTI IONTION NORDEN.	A. BUILD	DING	CONTELET	
** ***		095015	- B-WING		12/0	6/2007
	N BOONE LEWIS HEA	LTH CARE CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE  1380 SOUTHERN AVE SE  WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 386 F 425 SS=E	A review of the resic physician's progress 30, September 30, a was no evidence that resident's hand controlled to acknowledge of the second and the second a	lent's record revealed notes dated July 30, August and October 22, 2007. There at the physician addressed the ractures.  liew was conducted with cember 6, 2007 at 3:45 PM. and that the physician's progress owledge the resident's the record was reviewed	F 3	F 425 483.60(a),(b) PHARMACY SERVICES #1, #2  1. Director on Nursing called pharmacy to inform them of medication in the emergency and medication cart on 12-12-06-07 pharmacy came in exchange the boxes. The emedication was removed from medication on 12-5-07 by of murses.  2. All other emergency Medication carts were for expired medication removed as needed.  3. All licensed staff was in-set on 12-24-07 by the Educated DON on monitoring expired on the emergency boxes and medication carts.  4. Emergency medication boxed medication carts will be modely pharmacy monthly and unit managers/team lead and findings will be reported.	of expire cy box 5-07. In to xpired com charge  boxes and e checked ins and were  rviced or and d dates d es and nitored  ders weekly	12-28-07
	This REQUIREMEN	T is not met as evidenced		by pharmacy monthly and unit managers/team lead	ders weekly	12-28-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095015	B. WING		12/0	6/2007
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	LTH CARE CENTER	ı	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 425	(3) of three (3) nursifacility staff failed to from an emergency. The findings include The facility failed to from the emergency carts.  1. On Monday, Dec AM and 4:00 PM, do facility's emergency 946 in the first floor following expired drawn (2) vials of Furd December 1, 2007  One vial of Lidocain 1, 2007.  Two (2) vials of Diaz December 1, 2007  The expiration date October 2007.  During a face-to-face he/she stated that the nursing units two (2)	ons and staff interview, for three ng units, it was determined that remove expired medication box and medi cation carts.  Temove expired medications box and medication  Temove expired medications  Temove expired medications	F 425			
		ember 5, 2007, between 11:00 uring the inspection of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	<u></u>	095015	B: WING		12/0	6/2007
	N BOONE LEWIS HEA	ALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETION DATE
F 425	Continued From pa	age 26	F 425			
	the facility's medica were expired:	ation carts, the following drugs				
	2nd Floor Unit, Car One (1)- Ceftriaxor May 2007	t 2 -Team 1 ne 1gm reconstituted vial, expired		F 428 483.60(c) DRUG REGIMEN REVIEW  1. DON obtained orders for PT/INR for resident #4 on 12-5-07 and was drawn on 12-6-07. Pharmacy was called on 12-6-07 by the DON and informed of the missing		
	was expired at the	nowledged that the medication time of the observation.				
	vial, expired April 2	azine Injection 25mg/ml - 1ml 007		and informed of the missing pharmacy monitoring.	<b>;</b>	
	Employee #17 acki	nowledged that the medications time of the observation.		All other residents' identificanticoagulant therapy recover reviewed and correctenced by DON, Unit Man	rds ed as	
F 428 SS=D	483.60(c) DRUG R	EGIMEN REVIEW	F 428	Charge Nurses.		
The drug regimen of each resigner reviewed at least once a month pharmacist.  The pharmacist must report an		nce a month by a licensed ust report any irregularities to the n, and the director of nursing, and		3. All licensed staff was in-ser on 12-24-07 by the DON on policy and procedure for res on anticoagulants and pharm was sent a copy of the facilit policy on 12-6-07.	the idents nacy	·
				<ol> <li>Random chart audits for anti coagulant lab orders by unit manager and pharmacy will provide the consultant pharm</li> </ol>		
	Based on record re (1) of 27 sampled r the pharmacist faile	NT is not met as evidenced by: eview and staff interview for one esidents, it was determined that ed to identify the lack of dent #4 who was receiving in).		with a list of resident of resident anticoagulants for monitoring every 30 days and finding we reported in quarterly CQI.	ng	12-28-07

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
0,			A. BUI	LDING	<del></del>		
		095015	B. WIN	IG		12/0	6/2007
	N BOONE LEWIS HEA	LTH CARE CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		8-8-
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 428	Continued From pag	ge 27	F	428		-	
	The findings include	:					
	physician's order dar renewed November	t #4's record revealed a ted August 13, 2007 and 2007 directing, "Warfarin one (1) tab by mouth every day					
		nt #4's record revealed that ere not completed to monitor					
	"Acceptable intervals normally within the ra	nufacturer's recommendations, s for PT/INR determinations are ange of 1 to 4 weeks after a een determined" from the web ers-squib.					
1	revealed that the pha medications Septem December, 2007. The identified on the afor record lacked evider	dication Regimen Review" armacist reviewed the resident's ber, October, November and here were no irregularities rementioned reviews. The hoce that the pharmacist was no monitoring for the use			·		
	Employee #2 on Dec He/she acknowledge identify the lack of m	iew was conducted with cember 4, 2007 at 3:00 PM. ed that the pharmacist failed to conitoring for the use of d was reviewed December 4,					
F 431 SS=E	483.60(b), (d), (e) Ph	HARMACY SERVICES	F	431			
		ploy or obtain the services of a who establishes a system					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/06/2007		
	e =	095015	B. WING				
	ROVIDER OR SUPPLIER	EALTH CARE CENTER		138	ET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL REGULATORY	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 431	of records of recordugs in sufficient reconciliation; and in order and that is maintained and Drugs and biolog labeled in accorduncessory and cate expiration date with the facility must store compartments urand permit only access to the key. The facility must permanently affix controlled drugs Comprehensive Act of 1976 and except when the drug distribution	eipt and disposition of all controlled t detail to enable an accurate d determines that drug records are an account of all controlled drugs d periodically reconciled.  Icals used in the facility must be ance with currently accepted ciples, and include the appropriate autionary instructions, and the then applicable.  Ith State and Federal laws, the etail drugs and biologicals in locked ander proper temperature controls, authorized personnel to have	F	431	F 431 483.60,(d),(e) PHARMACY SERVICES  1. Multi-dose medication and that lacked date and initials first opened were discarded Reordered on 12-5-07.  2. All other medication carts a medication refrigerators we checked for compliance an corrected as needed.  3. Licensed staff was in-service 12-24-07 on dating and init Multi-dose medication vials when first open by Nurse Medication daily open vials for and report findings to quar CQI.	when and and and are days are	12-28-07
	This REQUIREM	IENT is not met as evidenced by:					
	(3) of three (3) not the facility staff fa	rations and staff interview, for three ursing units, it was determined that ailed to date and initial multi-dose when first opened.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		095015	B. WIN	G		12/06/2007	
	OVIDER OR SUPPLIER	LTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1380 SOUTHERN AVE SE  WASHINGTON, DC 20032				
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F 431	Continued From page	ge 29	F	431			
		07, between 11:00 AM and 4:00			·		
	PM, the medication inspected on each to	carts and refrigerators were unit.					
	1st Floor Unit						
	Xalatan ophthalmic	drops - two (2) vials			·		
		wledged that the vials of ve were not dated and/or of the observations.					
	2nd Floor Unit						
		drops - three (3) vials 30 ml - one (1) vial					
		owledged that the vials listed ed and/or initialed at the time of					
	3rd Floor Unit					,	
	PPD 5 TU/0.1ml - c Xalatan ophthalmic Sterile Water 30 ml	drops - one (1) vial					
F 441 SS=E		owledged that the vials listed ad and/or initialed at the time of ON CONTROL	F	441 <sup>.</sup>		·	
	control program des sanitary, and comfo	tablish and maintain an infection signed to provide a safe, ortable environment and to orment and transmission of					

1/4/28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
11.00		095015	B. WIN	G		12/0	6/2007
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	ALTH CARE CENTER		138	ET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032	12.0	0/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 441	infection control pro investigates, control facility; decides wha should be applied to maintains a record actions related to in This REQUIREMENT Based on observati determined that face effective infection could oxygen conclocated at a resident review of the facility failed to utilize collemeasures.  The findings included 1. Soiled oxygen coin rooms 128 and 1 were using the device of the Panafil was precalmoseptine was 3. The seat, back a 3rd floor B hallway This prompted a recontrol program.	on. The facility must establish an ogram under which it ls, and prevents infections in the at procedures, such as isolation of an individual resident; and of incidents and corrective fections.  AT is not met as evidenced by:  ons and staff interview, it was illity staff failed to maintain an ontrol program as evidenced by: entrator filters, medications at's bed side and a soiled chair. A r's infection control program ected data to initiate preventive ected.	F	441	F 441 483.65(a) INFECTION CONTROL #1, #2, #3  1. Charge nurse remove conditer on 12-03-07 from relation 128 and 126. Medication was removed from bedsictime of observation for relation was removed from bedsictime of observation for relation 120. The chair cited on the floor back hall that was stand soiled was discarded 12-5-07.  2. All other concentrators through the facility was inspect and filters were cleaned as and bedsides were checked medication and removed as reall furniture was checked for stained and was cleaned as The infection control policy Based infection control worldwere reviewed by the Adm Director of Quality Assurant And Unit Managers on 12-2 Ensure policy control comp	ooms  le at the sident he 3 <sup>rd</sup> ained on  ough ted needed d for needed asoiled/ needed. and unit k sheets inistrator, nee, DON, 20-07 to	

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUI	
		095015	B. WIN	IG		12/0	6/2007
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	LTH CARE CENTER		1:	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I' BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG	TX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS-	(XS) COMPLETION DATE
F 441	infection control proinvestigates, control facility; decides who should be applied to maintains a record actions related to in This REQUIREMENT Based on observati determined that face effective infection couled oxygen conclocated at a resider review of the facility failed to utilize colle measures.  The findings included 1. Soiled oxygen coin rooms 128 and 1 were using the devided 2. Panafil ointment observed at the best The Panafil was proceed as the process of the properties of the propertie	on. The facility must establish an gram under which it ls, and prevents infections in the at procedures, such as isolation of an individual resident; and of incidents and corrective fections.  It is not met as evidenced by: One and staff interview, it was stillity staff failed to maintain an control program as evidenced by: One trator filters, medications of sinfection control program as evidenced chair. A of sinfection control program acted data to initiate preventive of the contract of t	F	441	F 441 483.65(a) INFECTION CONTROL #1, #2, #3  1. Charge nurse removed confilter on 12-03-07 from race 128 and 126. Medication removed from bedside at time of observation for race #20 a new supply of oint ordered for resident #20. Chair cited on the 3rd flood hall that was stained and discarded on 12-5-07.  2. All other concentrators to Out the facility was inspected And filters were cleaned. And bedside were cheed Medication and remove And a new supply order Furniture was checked Stains and was cleaned. The infection control pounit based infection considers were reviewed by Administrator, Directon Assurance, DON and UOn 12-20-07 to ensure Control compliance.	the esident ment was The or back soiled was through bected it as needed ked for ed as needed red. All for soiled/as needed. olicy and introl work by the r of Quality Unit Managers	much 1/1/2

regustre 1/4/28

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095015	B. WING		12/0	06/2007	
	ROVIDER OR SUPPLIER  N BOONE LEWIS HE	EALTH CARE CENTER	s	TREET ADDRESS, CITY, STATE, ZIP COD 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE	
F 441	Employee #10. En he/she had been to coordinator for about the september 200 in place that I knew program. Becaus Portability and Account all the information was a count of the hospital. "  Employee #10 programs are acquired in the hospital."  Employee #10 programs infect quarterly monitoring August and Septemanterly monitoring acquarterly monitoring acquarterly monitoring acquarterly monitoring acquarterly monitoring acquarterly infection. "Statuses of concomposite of infections."  The quarterly sum of infections: Clostridium Difficil Methicillin resistand uring acquarterly infections - 8 Respiratory infect. There was a listing the sum of th	tember 5, 2007 at 1:40 PM with Employee #10 explained that the Infection Control Program out three (3) years.  Ited, "I started tracking infections 7. There was really nothing else w of prior to when I started this e of HIPPA (Health Insurance countability Act), I didn't write nation like organisms, antibiotics I did identify the infections that nouse and those that came from esented a monitoring tool ctions monthly and quarterly. A not good listing infections for July, mber 2007 was reviewed. The ns described in the terms for this quarter" were not enumber of infections described enumber of infections described enumber of infections described enumber of infections described enumber (C-Diff) - 1 at staphylococcus Aureus (MRSA) ctions (UTI) - 8 ions - 5	F 44	3. Nursing staff was in-s Unit Managers on clear Concentrator filters on On medication at the late-7-07 and housekee was in-serviced on 12 procedures for cleaning Director of Environme On 12-27-07 Director in-serviced Educator use of the infection consheets.  4. Random rounds will be ensure concentrators for clean, no medication and there are no furnit stained, and DON will usage of the infection worksheet and findings reported to quarterly Constants.	aning the in 12-3-07, bedside on pping staff -21-07 on ing chairs by ental Services. of Nursing on proper introl work  e done to ilters are it bedside it bedside it bedside it wonitor control it will be	12-28-07	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095015	B. WIN	IG	· · · · · · · · · · · · · · · · · · ·	12/0	6/2007
	ROVIDER OR SUPPLIER  N BOONE LEWIS HE	ALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1380 SOUTHERN AVE SE  WASHINGTON, DC 20032			·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 441	Employee #10. Enhe/she had been the coordinator for about the coordinate that I knew program. Because Portability and Accordinate the informused, and dates. I were acquired in hit the hospital. "  Employee #10 presummarizing infect quarterly monitorin August and Septer number of infection "Statuses of concoordinates of concoordinates of concoordinates."  The quarterly sum of infections: Clostridium Difficite Methicillin resistantum of infections - 8 Respiratory infections. There was a listing the coordinates of	ember 5, 2007 at 1:40 PM with imployee #10 explained that he Infection Control Program but three (3) years.  ed, "I started tracking infections of There was really nothing else of prior to when I started this e of HIPPA (Health Insurance ountability Act), I didn't write ountability Act), I didn't write outability the infections that ouse and those that came from sented a monitoring tool ions monthly and quarterly. A g tool listing infections for July, inber 2007 was reviewed. The list described in the erns for this quarter" were not number of infections described mary listed the following number as (C-Diff) - 1 at staphylococcus Aureus (MRSA) attons (UTI) - 8 and - 5	F	441	<ol> <li>Nursing staff was in-service Unit Managers on cleaning Concentrators filters on 12 On medication at the bedsi ad on not using other resid medication         12-7-07 and housekeeping was in-serviced on 12-21-c procedures for cleaning che Director of Environmental On 12-27-07 Director of N In-serviced Educator on procedures of the infection control Sheets.</li> <li>Random rounds will be done Ensure concentrators filters Clean, no interexchange of Residents' medication for unitarity will be medication at the bed single There are no furniture soile And DON will monitor usate The infection control works and findings will be reported Quarterly CQI.</li> </ol>	g the 3-3-07, ide ent's staff 07 on airs by Services. ursing oper I work  the to are other usage, de and d/stainded ge of theet	12-28-07
	UTI - 5		•				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	<del></del>	095015	B. WING		12/06/2007
	OVIDER OR SUPPLIER	ALTH CARE CENTER	\ · 1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	
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F 441	number of infection summary and the insummary and the increased based or residents and the insummary and the increased based or residents and the insummary	anation for the difference in the as listed on the quarterly number of infections listed by unit.  The ded that there is an infection conducted monthly. There was no data collected monthly regarding zed to initiate measures to	F 441	F456 483.70(c)(2) SPACE AND EQUIPMENT #1  1. The washer that was cite laundry room with no the to monitor water tempera the survey period is being	ermometer ature during g cleaned and
F 456 SS=E	The facility must m	ce and equipment  naintain all essential mechanical, ent care equipment in safe  n.	F 456	sanitized by a laundry co water temperature below  2. All other washers were in proper amounts of composeing released from disperature proper and sanitizing of cleaning and sanitizing of	aspected to bund are enser

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
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		ALTH CARE CENTER	1:	EET ADDRESS, CITY, STATE, ZIP.CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
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F 456	Based on observa review, it was determaintain laundry econdition. Addition a log documenting coming into the warmade in the preses 3, 2007 at 2:15 PM. The findings included 1. Two (2) of three the time of the obsthermometer on the temperature in one washers observed washer with a their degrees Fahrenhe washer.  Subsequent to the staff removed the staff	tions, staff interview and record armined that facility staff failed to equipment in safe operating hally, facility staff failed to maintain the temperature of the water afters. These observations were note of Employee #5 on December of M.  de:  (3) washers were in service at servation. There was note emiddle washer to monitor water at (1) of two (2) functioning. It was observed that the distal mometer had a reading of 180 with of water coming into the servation in the washers, facility water temperature gauge from the was out of service) and placed it her. The temperature of the the washer was 180 degrees  lence that facility staff maintained the temperature of the water ashers.  2) washers were observed wash cycle.	F 456	<ol> <li>In-service was given to laur Supervisor by Director of I mental Service on inspecting for cleanliness after remove washer on 12-21-07.</li> <li>Monitoring will be done dated laundry supervisor and find will be reporter in quarterly #2</li> <li>The two washers observed be Leaking washer will be replayed On doors by 12-28-07.</li> <li>Maintenance staff will cond monthly checks on washers ensure compliance.</li> <li>Maintenance staff was in-sea On 12-26-07 by maintenance supervisor on preventative maintenance of washer and</li> <li>Monitoring for compliance washer and dryers findings be reported in quarterly CQ</li> </ol>	Environ- ing clothes ing from  ily by lings CQI.  eaking acced  uct to  rviced ce dryers	12-28-07
F 469	the time of the obs	nowledged the above findings at servations.  SICAL ENVIRONMENT- PEST	F 469			

	PLAN OF CORRECTION IDENTIFICATION NUMBER:			(3) DATE SURVEY COMPLETED		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			A. BUILDI	NG	33 22	
		095015	B. WING_		12/0	06/2007
	ROVIDER OR SUPPLIER	ALTH CARE CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
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F 469 SS=C	CONTROL  The facility must m program so that the rodents.  This REQUIREMEI Based on observat was determined the pest free environment.  The findings include Flying or crawling in 1. On December 3, observed in rooms 1st floor dining room 2. On December 4, observed in the 1st and 10:05 AM, 2nd AM, room 114 at 11 and 3rd floor nursin A roach was observed in floor nursin 3. On December 5, observed in room 1 room at 9:00 AM, go	aintain an effective pest control efacility is free of pests and  NT is not met as evidenced by: ions during the survey period, it at facility staff failed to maintain a ent.  e:  nsects were observed as follows:  2007, flying insects were 108 and 115 at 12:15 PM and	F 46	9 F 469 483.70 (h)(4) PHYSICAL ENVIRONME CONTROL  #1, #2, #3, #4  1. Room 108, 114, 115, 1st, 2 and 3rdfloor nursing station 1st, 2nd, 3rd and ground flood dining rooms were cleaned and trash removed on 12-that were cited during sur with flying insects. Pest control contractor came in 12-7-07 and 12-18-07 to exterminate the facility.  2. All other residents' rooms checked for insects and exand cleaned as needed. The are being cleaned weekly to prevent further occurred.  3. Housekeeping staff was in serviced on 12-21-07 for removal, cleaning of trash and proper cleaning techn by environmental services director.  4. Weekly rounds will be conditioned in the condition of the condit	2 <sup>nd</sup> ons oor ed -7-07 ey n on s were xterminated rash cans y and prn ences. n- trash a cans iques s	12-28-07
	Hivi and 2nd floor d	ining room at 4.00 PM.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPL	E CONSTRUCTION	(X3) DATE SUI	
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F 469	4. On December 6 observed in the 3r and 2nd floor halls  A face-to-face into Employee #5 on E He/she stated, "[A spray every week.]	page 35 6, 2007, flying insects were red floor dining room at 10:20 AM way by room 207 at 2:30 PM.  Perview was conducted with December 6, 2007 at 9:30 AM. A pest control company] comes to . We still have some problems awling insects and mice."	F	469			
F 492 SS=D	compliance with a local laws, regulat accepted profession apply to profession facility.  This REQUIREME Based on a review sheets and staff in days reviewed, it will failed to maintain per resident per different fundings included to the findings included to the findings included the fin	operate and provide services in applicable Federal, State, and cions, and codes, and with onal standards and principles that nals providing services in such a service in such as services in such a service in such as services in such as services in such as services in such as services in such a service in such as services	F		<ol> <li>F 492 483.75(b)         ADMINSTRATION         <ol> <li>A tickler sheet has been developed and given to DON, Staffing Coordinator and Supervisors to staff facility Based on census and staff Have been instructed to Utilized agency and overtime When call-ins have occurred.</li> <li>Staffing sheets will be reviewed daily by DON, staffing coordinator and supervisors to ensure compliance and facility will overstaff to allow for call ins.</li> <li>In-service was given to staffing coordinator and supervisors on 12-07-07 of staffing facility appropriately by DON.</li> </ol> </li> <li>Daily monitoring will be done by DON, Staffing Coordinator and Supervisors and findings reported in quarterly CQI.</li> </ol>		12-28-07

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUI COMPLET	
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F 492	Continued From page 4 and 5, 2007 and restaffing on the follow	evealed inadequate nurse	F	492			
F 514 SS=D	face-to-face intervie Employee #8 who a was below 3.5 nursidue to staff not repostated, "The agenci Sometimes the age the agency does no person who called in 483.75(I)(1) CLINIC The facility must maresident in accordar standards and pract accurately documer systematically organ. The clinical record resident's assessme services provided; to	AL RECORDS  sintain clinical records on each nee with accepted professional tices that are complete; nted; readily accessible; and	F	514			
·	Based on staff inter	View and record review for four esidents, it was determined that consistently					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBÉR:	(X2) M A. BU		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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F 514	document one (1) rediscontinue medicat treatments on month residents. Resident  The findings include  1. Facility staff failed Resident #4's skin of the facility's policy revised August 3, 20 breaks in skin integrated to breakdown) stassiculcer flow sheet)"	esident's skin condition, and alons, laboratory studies and alony physician's orders for two (2) is #4, 7 and 14.  It to consistently document condition.  Sentitled, "Skin Integrity Program" 207 revealed, "Procedure for ity:6. The charge nurse will cumentation of all wounds (skin is ulcer flow sheets or pressure	F	514	F 514 483.75(i)(1) CLINICAL RECORDS #1 Resident #4  1. Charge Nurse obtained and For treatment and the skin Was updated on 12-4-07 at Of survey.  2. All other residents had a here Toe skin assessment on	sheet the time	
	"Skin Assessmen observed"; Braden 12 or less represent The "Pressure Ulcer revealed, "Location: 27, 2007, Stage I, Munopened discolora September 5, 2007, cm, unopened discolora October 3, 2007, Stagen Branulation tiss The "Wound Report "Original date identification acquired: facility, Right 1.5 cm, description August 29, 2007 - n	t: "Skin is dry, no open area Scale: Score total-14 [Total of s high risk]".  r Report" form for Resident #4 Left foot side posterior; August leasurement-5 x 5 cm,			12-7-07, 12-10-07 and 12-1 to ensure no wounds or skir condition was missed and of as needed.  3. All staff was in-serviced or proper use of the skin and sheets and wound assessment 12-7-07 by DON.  4. Random audits of skin and book will be done weekly be Unit Managers and Charge And findings will be reported Quarterly CQI.	n the bath ents on bath by Nurses	12-28-07

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIENCLIA  · IDENTIFICATION NUMBER:	A. BUIL		G	(X3) DATE SUF	
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F 514	drainage/odor pink October 3, 2007, F. cm, dark pigment a odor or drainage. A review of the ph September 14 and evidence that the ph september 14 and evidence in september 14 and eviden	sish with granulation; Right Ankle, Measurement- 2 x 2 Ition with dry [unable to read] no  ysician's progress notes dated October 30, 2007 lacked ohysician addressed Resident  ess notes revealed the following: at 8:00 PM: "Resident readmitted ospital name]Feet no open area no open area" at 10:00 PM: "Open blister to 5 cm noted pink and dry. Doctor re ordered tx [treatment]" a 3:00 PM: "Weekly wound lone today to left foot and right See weekly skin assessment open areas noted" at at 3:00 PM: "Resident has a a pulling from skin, no odor Area is unopened on outer side leasures 2.5 x 2.5 cm"  rview was conducted with recember 4, 2007 at 3:00 PM. re ulcers are healing." Employee that the record lacked consistent e record was reviewed on  ed to discontinue a treatment and onthly physician's orders for sident #7 had an open wound on	F	514	#2 and #3 Residents #7 & #14  1. The POS and MAR was concentration of the resident #7 for disconsequence of the resident #14 for lab orders on 12-5-07.  2. All other residents' charts reviewed for compliance Corrections were done as a service of the resident was in-serviced reviewing the monthly POMAR and documentation 12-27-07 by Unit Manager was and night Charge Nurses of the reported in quarter will be reported in quarter.	were and needed. ed on OS/ on rs. es will nager to dings	12-28-07

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
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F 514	physician's order "Discontinue Give (twice daily) 30 m Discontinue Zinc wound healing. D bid for wound hea thigh open area w then apply Panafi days."  According to the form (monthly ord were included on the form on Nove		F 514		-	
	Employee #3 on He/she acknowle orders should har monthly physicial reviewed December 3. Facility staff fa	erview was conducted with December 5, 2007 at 11:30 AM. dged that the aforementioned we been discontinued on the n's order form. The record was ber 5, 2007.  illed to discontinue laboratory ly physician's order forms for				
	A review of Resic physician's order "Discontinue Hgb 3 months. Patien The physician's of	dent #14's record revealed a dated August 8, 2007, directed, A1C (Glycosylated Hemoglobin) q t is not diabetic."  order forms (monthly orders) were visician on September 16, October			,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE	(X3) DATE SÜRVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1380 SOUTHERN AVE SE  WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS-	(X5) COMPLETION DATE	
F 514	There was no evid HgbA1C was draw A face-to-face inte Employee #3 on D He/she acknowled been discontinued September, Octob	age 40 months Feb/May/Aug/Nov."  lence in the record that the  n for November 2007.  rview was conducted with  lecember 4, 2007 at 3:00 PM.  lged that the order should have  on the physician's order forms for  ler and November 2007. The  led December 4, 2007.	F 5	14			